Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-06-5782-01 (previously M4-05-6599-01)

MDFR Received Date
NOVEMBER 11, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All out of pocket expenses paid due to work injury."

Amount in Dispute: $3,154.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Insurance Carrier did not submit a position summary with their response to the request for medical fee dispute resolution.

Response Submitted by: Speciality Risk Services, 300 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2003 – October 7, 2003	Physical Therapy Co-Pays	$110.06	$10.60
January 8, 2004 – April 28, 2004	Out-of-Pocket Expenses – Prescriptions	$102.17	$0.00
December 4, 2003 – January 2, 2004	Out-of-Pocket Expenses – Office vists (2) and NCV testing	$165.32	$0.00
August 21, 2003 – September 18, 2003	60% Employee suffer from same injury. Repetitive motion, typing/writing 8 hrs day	$2,625.30	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the guidelines for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.307(f) sets out the guidelines for injured employees to obtain

reimbursement from the insurance carrier for out-of-pocket expenses incurred by injured employee.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 11, 20010
   - W3 – Additional payment made on appeal/reconsideration. Reimbursement reflects the balance due per fee/ucr less any amounts we previously paid.

Issues

1. Did the Requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the Respondent reimburse the requestor in accordance with 28 Texas Administrative Code §133.307(f)?
3. Did the Respondent reimburse the requestor in accordance with 28 Texas Administrative Code §133.307(f)?
4. Did the Respondent reimburse the requestor in accordance with 28 Texas Administrative Code §133.307(f)?
5. Did the Requestor submit documentation to support the service from August 21, 2003 throughSeptember 18, 2003

Findings

1. Per 28 Texas Administrative Code §133.307(d)(1) the requestor has timely filed the request for medical fee dispute resoltution.
2. The requestor submitted receipts showing out-of-pocket expenses were incurred for physical therapy in the amount of $110.60. The insurance carrier submitted an EOB and payment summary screen showing payment of $100.00 with check number 10532008 was made to the injured worker. Therefore, in accordance with 28 Texas Administrative Code §133.307(f) additional reimbursement is recommended.
3. The requestor submitted receipts showing out-of-pocket expenses were incurred for prescription medications in the amount of $102.17. The insurance carrier submitted a payment summary screen showing payment of $102.66 with check number 105820030 was made to the injured worker. Therefore, in accordance with 28 Texas Administrative Code §133.307(f) no additional reimbursement is due.
4. The requestor submitted receipts showing out-of-pocket expenses were incurred. The first receipt was a statement of account dated December 4, 2003 for an office visit and muscle testing for two limbs, motor nerve testing and sensory nerve testing and Moto, with F-Wave study. The copy of the statement of account for the testing shows a balance due of $135.33; however on the statement it shows an additional charge of $11.99 was added to the balance due bring the total balance due of $147.32. Documentation to support the extra charge of $11.99 was not submitted. The second receipt, dated January 2, 2004, was for an office visit with a balance due of $18.00. The insurance carrier submitted a payment summary screen, dated January 11, 2010 showing payment in the amount of $153.33 with check number 105620020 was made to the injured worker. Therefore, in accordance with 28 Texas Administrative Code §133.307(f) no additional reimbursement is due.
5. The requestor also submitted a table of disputed services for dates of service August 21, 2003 through September 18, 2003 totaling $2,625.30. Review of the dispute contents submitted by the injured worker finds no receipts or other documentation to support what these charges represent. According to the table of disputed services “Requestor’s Rational for Increased Reimbursement or Refund” the injured worker states “60% employee suffer from sam injury repetitive motion typing/writing 8 hrs day Bad Faith claim handling”, it appears the employee is requesting payment for lost wages as no other receipts for medical services were submitted. In accordance with 28 Texas Administrative Code 133.305(a)(2), Medical Fee Disputes involve a dispute over the pamount of payment for health care rendered to an injured employee. Since the requestor has not submitted any documentation to support these charges; reimbursement is not recommended.
6. Review of the submitted documentation finds that additional reimbursement is due

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $10.60.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 11, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.